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EDITORIAL

Making Doctors

In 1723, Peter the Great, Czar of Russia, began to die. He lay in bed in excruciating pain, unable to void. After many bloody attempts, a catheter was finally passed and later that day he passed a large stone. Based on fragmentary information, it appears most likely that he suffered from prostatic obstruction and bladder stones. Although many physicians examined Peter the Great, only one, the eminent Dutch physician Boerhaave, seemed to have a hint of what ailed him. Boerhaave was summoned too late; he never got to examine the Russian czar. But when he heard the facts, he remarked, ''What a pity that so great a man should have died when a pennyworth of medicine might have saved his life.''

''A pennyworth of medicine?'' Did Boerhaave know of a pill that could have saved the Czar's life? Did he alone know of, and have, such a pill? We'll probably never know, but there are some things that we do know. We know that effective treatment is best accomplished when predicated on an accurate diagnosis.

In the current issue of this journal, Madersbacher et al., on the basis of urodynamic studies, report that bladder compliance was reduced in more than a third of men over the age of 50 years who complained of lower urinary tract symptoms. Further, low bladder compliance correlated with urethral obstruction, detrusor instability, prostate size, and age. It is well known that low bladder compliance is an important risk factor for the development of bladder and kidney damage. It appears to represent a final common pathway, caused by many different conditions, that ultimately leads to high detrusor pressures that adversely affect the bladder and kidney. Most important, however, when diagnosed early and treated properly, it is probably reversible.

The deleterious effects of low bladder compliance were first documented in myelodysplastic children by Ed McGuire [1] in 1981. What is not so well known, though, is how Dr. McGuire came to appreciate the deleterious affects of low bladder compliance. It happened because he performed the urodynamics studies himself, treated the patients himself, and made the clinical observations that ultimately became the subject of scientific scrutiny. That is the way science progresses.

In the cost-conscious age in which we live, there are increasing economic pressures to follow algorithms and ''critical pathways.'' Such pathways reserve urodynamics for treatment failures, patients with known risk factors or those with known kidney and bladder damage. Low bladder compliance, however, can only be diagnosed by urodynamics.

Following such algorithms then, Peter the Great himself would still have had to wait until he developed urinary retention or stones before he could be properly diagnosed. He likely would not have died so soon because treatments are so much better now, but he would still have had to suffer a bit before the proper diagnosis was

made. More important, though, if we deny physicians access to the diagnostic tools that enable them to detect the subtle differences among patients, we deny them the ability to make independent observations and to learn from their own experience. This serves only to thwart the creative process, impede medical progress, and ultimately diminish the standard of care. In addition, it denies physicians such as Dr. McGuire the opportunity to perform routine urodynamics, to discover things like the deleterious effect of low compliance in the first place, and to discover that with early diagnosis and treatment it might be reversible.

Algorithms may be useful in some instances, but it is equally important that physicians have the perogative, with the consent of the patient, to do whatever is reasonably necessary to gather the information that leads to an accurate diagnosis. Armed with this clinical information, the physician gains experience. As he learns from his experience, he achieves expertise, and some even become pre-eminent in their field like the great Dutch physician Boerhaave.

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REFERENCE

McGuire EJ, Woodside JR, Borden TA, et al. The prognostic significance of urodynamic testing in myelodysplastic patients. J Urol 1981;125:205.